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109TH CONGRESS
1ST SESSION

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To provide grants for rural health information technology development activities.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 2, 2005

Mr. COLEMAN (for himself, Mr. BAYH, Mr. CORNYN, and Mr. LUGAR) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To provide grants for rural health information technology development activities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Critical Access to Health Information Technology Act of 2005''.

SEC. 2. HEALTH INFORMATION TECHNOLOGY GRANT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish and implement a program to

award grants to increase access to health care in rural areas by improving health information technology, including the reporting, monitoring, and evaluation required under this section.

(b) STATE GRANTS.—The Secretary shall award grants to States to be used to carry out the State plan under subsection (e) through the awarding of subgrants to local entities within the State. Amounts awarded under such a grant may only be used in the fiscal year in which the grant is awarded or in the immediately subsequent fiscal year.

(c) AMOUNT OF GRANT.—From amounts appropriated under subsection (k) for each fiscal year, the Secretary shall award a grant to each State that complies with subsection (e) in an amount that is based on the total number of critical access hospitals in the State (as certified by the Secretary under section 1817(e) of the Social Security Act) bears to the total number of critical access hospitals in all States that comply with subsection (e).

(d) LEAD AGENCY.—A State that receives a grant under this section shall designate a lead agency to—

(1) administer, directly or through other governmental or nongovernmental agencies, the financial assistance received under the grant;

(2) develop, in consultation with appropriate representatives of units of general purpose local government and the hospital association of the State, the State plan; and

(3) coordinate the expenditure of funds and provision of services under the grant with other Federal and State health care programs.

(e) STATE PLAN.—To be eligible for a grant under this section, a State shall establish a State plan that shall—

(1) identify the State's lead agency;

(2) provide that the State shall use the amounts provided to the State under the grant program to address health information technology improvements and to pay administrative costs incurred in connection with providing the assistance to local grant recipients;

(3) provide that benefits shall be available throughout the entire State; and

(4) require that the lead agency consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds received under the grant.

(f) AWARDING OF LOCAL GRANTS.—

(1) IN GENERAL.—The lead agency of a State shall use amounts received under a grant under subsection (a) to award local grants on a competitive basis. In determining whether a local entity is eligible to receive a grant under this subsection, the lead agency shall utilize the following selection criteria:

(A) The extent to which the entity demonstrates a need to improve its health information reporting and health information technology.

(B) The extent to which the entity will serve a community with a significant low-income or other medically underserved population.

(2) APPLICATION AND APPROVAL.—To be eligible to receive a local grant under this subsection, an entity shall be a government-owned or private nonprofit hospital (including a non-Federal short-term general acute care facility that is a critical access hospital located outside a Metropolitan Statistical Area, in a rural census tract of a Metropolitan Statistical Area as determined under the most recent version of the Goldsmith Modification or the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy of the Health Resources and Services Administration, or is located in

an area designated by any law or regulation of the State in which the hospital is located as a rural area (or is designated by such State as a rural hospital or organization)) that submits an application to the lead agency of the State that—

(A) includes a description of how the hospital intends to use the funds provided under the grant;

(B) includes such information as the State lead agency may require to apply the selection criteria described in paragraph (1);

(C) includes measurable objectives for the use of the funds provided under the grant;

(D) includes a description of the manner in which the applicant will evaluate the effectiveness of the activities carried out under the grant;

(E) contains an agreement to maintain such records, make such reports, and cooperate with such reviews or audits as the lead agency and the Secretary may find necessary for purposes of oversight of program activities and expenditures;

(F) contains a plan for sustaining the activities after Federal support for the activities has ended; and

(G) contains such other information and assurances as the Secretary may require.

(3) USE OF AMOUNTS.—

(A) IN GENERAL.—An entity shall use amounts received under a local grant under this section to—

(i) offset the costs incurred by the entity after December 31, 2005, that are related to clinical health care information systems and health information technology designed to improve quality of health care and patient safety; and

(ii) offset costs incurred by the entity after December 31, 2005, that are related to enabling health information technology to be used for the collection and use of clinically specific data, promoting the interoperability of health care information across health care settings, including reporting to Federal and State agencies, and facilitating clinic decision support through the use of health information technology.

(B) ELIGIBLE COSTS.—Costs that are eligible to be offset under subparagraph (A) shall include the cost of—

(i) purchasing, leasing, and installing computer software and hardware, including handheld computer technologies, and related services;

(ii) making improvements to existing computer software and hardware;

(iii) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange;

(iv) services associated with acquiring, implementing, operating, or optimizing the use of new or existing computer software and hardware and clinical health care information systems;

(v) providing education and training to staff on information systems and technology designed to improve patient safety and quality of care; and

(vi) purchasing, leasing, subscribing, integrating, or servicing clinical decision support tools that integrate patient-specific clinic data with well-established national

treatment guidelines, and provide ongoing continuous quality improvement functions that allow providers to assess improvement rates over time and against averages for similar providers.

(4) GRANT LIMIT.—The amount of a local grant under this subsection shall not exceed $250,000.

(g) REPORTING, MONITORING, AND EVALUATION.—The lead agency of a State that receives a grant under this section shall annually report to the Secretary—

(1) the amounts received under the grant;

(2) the amounts allocated to State grant recipients under the grant;

(3) the breakdown of types of expenditures made by the local grant recipients with such funds; and

(4) such other information required by the Secretary to assist the Secretary in monitoring the effectiveness of activities carried out under this grant.

(h) REVIEW OF COMPLIANCE WITH STATE PLAN.—The Secretary shall review and monitor State compliance with the requirements of this section and the State plan submitted under subsection (e). If the Secretary, after reasonable notice to a State and opportunity for a hearing,

finds that there has been a failure by the State to comply substantially with any provision or requirement set forth in the State plan or the requirements of this section, the Secretary shall notify the lead agency involved of such finding and that no further payments to the State will be made with respect to the grant until the Secretary is satisfied that the State is in compliance or that the noncompliance will be promptly corrected.

(i) PREEMPTION OF CERTAIN LAWS.—The provisions of this section shall preempt applicable Federal and State procurement laws with respect to health information technology purchased under this section.

(j) RELATION TO OTHER PROGRAMS.—Amounts appropriated under this section shall be in addition to appropriations for Federal programs for Rural Hospital FLEX grants, Rural Health Outreach grants, and Small Rural Hospital Improvement Program grants.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for each of fiscal years 2006 through 2008.

SEC. 3. REPLACEMENT OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES.

(a) IN GENERAL.—Not later than October 1, 2006, the Secretary of Health and Human Services shall promulgate a final rule concerning the replacement of the Inter-

national Statistical Classification of Diseases, 9th revision, Clinical Modification (referred to in this section as the ''ICD–9–CM''), under the regulation promulgated under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), including for purposes of part A of title XVIII, or part B where appropriate, of such Act, with the use of each of the following:

(1) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (referred to in this section as ''ICD–10–CM''.

(2) The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification Coding System (referred to in this section as ''ICD–10–PCS'').

(b) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall ensure that the rule promulgated under subsection (a) is implemented by not later than October 1, 2009. In carrying out the preceding sentence, the Secretary shall ensure that such rule ensure that Accredited Standards Committee X12 HIPAA transactions version (v) 4010 is upgraded to a newer version 5010, and that the National Council for Prescription Drug Programs Tele-

communications Standards version 5.1 is updated to a newer version (to be released by the named by the National Council for Prescription Drug Programs Telecommunications Standards) that supersedes, in part, existing legislation and regulations under the Health Insurance Portability and Accountability Act of 1996.

(2) AUTHORITY.—The Secretary of Health and Human Services shall have the authority to adopt, without notice and comment rulemaking, standards for electronic health care transactions under section 1173 of the Social Security Act (42 U.S.C. 1320d–2) that are recommended to the Secretary by the Accredited Standards Committee X12 of the American National Standards Institute in relation to the replacement of ICD–9–CM with ICD–10–CM and ICD–10–PCS. Such modifications shall be published in the Federal Register.

(c) NOTICE OF INTENT.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall issue and publish in the Federal Register a Notice of Intent that—

(1) adoption of Accredited Standards Committee X12 HIPAA transactions version (v) 5010 shall occur not later than April 1, 2007, and compli-

ance with such rule shall apply to transactions occurring on or after April 1, 2009;

(2) adoption of the National Council for Prescription Drug Programs Telecommunications Standards version 5.1 with a new version will occur not later than April 1, 2007, and compliance with such rule shall apply to transactions occurring on or after April 1, 2009;

(3) adoption of ICD–10–CM and ICD–10–PCS will occur not later than October 1, 2006, and compliance with such rules shall apply to transactions occurring on or after October 1, 2009; and

(4) covered entities and health technology vendors under the Health Insurance Potability and Accountability Act of 1996 shall begin the process of planning for and implementing the updating of the new versions and editions referred to in this subsection.

(d) ASSURANCES OF CODE AVAILABILITY.—The Secretary of Health and Human Services shall take such action as may be necessary to ensure that procedure codes are promptly available for assignment and use under ICD–9–CM until such time as ICD–9–CM is replaced as a code set standard under section 1173(c) of the Social Security Act with ICD–10–PCS.

(e) DEADLINE.—Notwithstanding section 1172(f) of the Social Security Act (42 U.S.C. 1320d–1(f)), the Secretary of Health and Human Services shall adopt the modifications provided for in this section without a recommendation of the National Committee on Vital and Health Statistics unless such recommendation is made to the Secretary on or before a date specified by the Secretary as consistent with the implementation of the replacement of ICD–9–CM with ICD–10–CM and ICD-10-PCS for transactions occurring on or after October 1, 2009.

(f) LIMITATION ON JUDICIAL REVIEW.—The rule promulgated under subsection (a) shall not be subject to judicial review.

(g) APPLICATION.—The rule promulgated under subsection (a) shall apply to transactions occurring on or after October 1, 2009.

(h) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as effecting the application of classification methodologies or codes, such as the Current Procedural Terminology (CPT) as maintained and distributed by the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS) as maintained and distributed by the Department of Health and Human Services, other than under the Inter-

national Statistical Classification of Disease and Related Health Problems.

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